DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. BUILDING _____ B. WING _____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP	1601 5TH AVENUE SAN RAFAEL, CA 94901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 7 Based on interview and record reviews, the facility failed to have a system to track PPD (The PPD skin test is a method used to diagnose silent [latent]Tuberculosis (TB) infection. PPD stands for purified protein derivative.) for 3 sampled residents (Resident 2,6& 7) and pneumonia vaccine for 2 sampled residents (Resident 6&7) with the potential for the residents to not receive the vaccine and be susceptible to Tuberculosis, and pneumonia virus. Findings: Review of facility documentation received on 1/30/14, revealed 3 out of 13 sampled residents (Resident 2,6,&7) did not have documented evidence of receiving PPD skin test upon admission,and no documentation that Resident 6&7 received pneumonia vaccine prior to admission to the facility On 1/31/14 Management Staff A was asked for facility policy regarding immunization, none was offered	F 334	4. A Tracking sheet will be maintained by DSD/designee indicating date PPD testing was done and date for next testing. An updated copy of the tracking sheet will be submitted by the DSD to the DON for review monthly. Results of audit will be reported to DON. DON/supervisor will ensure completion of required testing. DON will provide a summary trends analysis of the audit findings to the CQI committee for further evaluation and/or recommendations.	3/7/14
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident	F 353		

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F 353	Continued From page 8 care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure sufficient staffing to meet resident needs during times when some residents required one-to-one supervision. Findings: During an interview on 1/28/14 at 11:50 a.m., Unlicensed Staff L stated that the two residents in Room 2 required continuous supervision (also known as one-to-one supervision) for safety. Unlicensed Staff L stated that the supervision was provided by rotating the scheduled nursing assistants (CNAs) so that each sat in the room for an hour in the morning and an hour in the afternoon. Unlicensed Staff L further stated that the CNAs usually had nine residents assigned to their care, and two hours per shift spent "sitting" in Room 2 caused some residents to miss scheduled showers or "get ignored." During an interview on 1/31/14 at 2:00 p.m., Unlicensed Staff M stated that additional staffing	F 353	F 353 1. Resident requiring 1:1 monitoring no longer requires this level of supervision. 2. Facility residents have been reviewed and no other residents require 1:1 supervision.	

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F 353	Continued From page 9 was provided for the one-to-one supervision in Room 2 while surveyors were present, but the supervision was usually provided by rotating the scheduled CNAs. Unlicensed Staff M stated that spending two hours per shift sitting with residents requiring one-to-one supervision left only five and a half hours to care for the CNA's normal load of nine assigned residents. During an interview on 1/30/14 at 3:20 p.m., Licensed Staff I stated that three CNAs were normally assigned to each of the two units on day shift. When one-to-one supervision was required, the CNAs are rotated to sit, usually for one hour at a time. This left two CNAs to provide care and answer call lights for all of the other residents on the unit. During the initial tour on 1/28/14, Resident 3 was asked how quickly she received help if she used her call light. Resident 3 stated, "It takes a while. They don't have enough help." During observation on 1/30/14 at 8:30 a.m., the call system for Resident 5, which included a light over the door to the resident's room and a continuous audible tone at the nurses station, was activated. Four minutes later, a visitor exited Resident 5's room, spoke to a licensed nurse at the medication cart in the hall, and returned to the room. At 8:40 a.m., a staff member walked into the hall, glanced at the light over Room 5, and entered the public restroom. At 8:42 a.m., the visitor stuck her head out of Room 5 and looked up and down the hall. At 8:43 a.m., Management Staff B walked down the hall, passing Room 5 twice while the light was illuminated and the alarm was sounding. At 8:44 a.m., fourteen minutes after the initial call for help, Unlicensed Staff M	F 353	3. The Interdisciplinary team will determine the need for 1:1 supervision for resident's safety. The Primary care provider will also be notified. Determination will also include what particular shifts are needed. A comprehensive care plan will be developed and other safety options will be included and attempted prior to initiation of 1:1 supervision. When resident is determined to require 1:1 supervision the DSD/designee will be notified to provide staffing support. The DSD/designee will provide the administrator and DON of a schedule of 1:1 staffing for the required shifts. If designated C.N.A is ill or unable to work on the scheduled shift, the DSD/designee will attempt to find alternate placement.	3/7/14

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F 353	Continued From page 10 entered the room to assist Resident 5. Unlicensed Staff M stated she had not worked with Resident 5 before and was not assigned to her, but was responding to Resident 5's need for assistance. Shortly thereafter, Unlicensed Staff N approached Room 5. Unlicensed Staff N confirmed that he was assigned to care for Resident 5, but he had been busy caring for a resident in another room. Review of the clinical record for Resident 25 included documentation, dated 1/23/14, that the CNA "did not have time to get [Resident 25] up in the [wheel chair] because I sat down with [Resident 22] from 9 a.m. to 10 a.m." Review of the clinical record for Resident 22 included the following: A Care Plan titled "Actual Fall" included an entry, dated 1/20/14, for "1:1 with CNA for prevention of falls injury." A Nurse's Note dated 1/11/14 at 6 p.m. referred to a "CNA sitter." A Nurse's Note dated 1/23/14 at 11 p.m., indicated, "sitter at his side for most of the shift." A Nurse's Note, dated 1/28/14 at 2 p.m., indicated "continues to be 1:1 with staff member." Review of the clinical record for Resident 23 included the following documentation of ongoing need for one to one supervision: A Care Plan titled "Psychosocial" reflected an entry on 1/24/14 for "Room change due to monitoring resident 1:1 fall risk patient." A Nurse's Note dated 1/20/14 at 11 p.m. documented, "1:1 sitter during whole shift."	F 353	4. DON/Supervisor/MOD will monitor that 1:1 supervision is being maintained. DON will provide a summary trend analysis of monitoring to the CQI steering committee for further evaluation and/or recommendations.	

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F 353	Continued From page 11 A Nurse's Note dated 1/22/14 at 11 p.m. documented, "1:1 supervision provided." A Nurse's Note dated 1/23/14 at 6:50 a.m. documented, "Kept on 1:1 throughout the night." A Nurse's Note dated 1/23/14 at 11 p.m. indicated, "Resident continues to need one on one care." A Nurse's Note dated 1/24/14 at 11 p.m. indicated, "Needs 1:1. Needs constant reminder to stay seated in wheelchair." A Nurse's Note dated 1/25/14 at 3 p.m. documented, "Sitter at bed/chair side all shift." During review of the staff assignment sheets on 1/31/14, the assignment sheets for day and evening shifts from 1/20/14 through 1/25/14 indicated the following: Eight of twelve shifts reviewed did not have a CNA assigned to provide one-to-one supervision of either Resident 22 or Resident 23; The six CNAs per shift had an assignment of eight to ten residents each. Only one shift had CNAs specifically assigned to provide supervision for Residents 22 and 23. Two shifts had staff assigned to supervise Resident 22, but not Resident 23. On January 25, 2014, when both residents were in the same room for supervision by one sitter, the assigned CNAs on day and evening shifts also had eight other residents for whom to provide care.	F 353		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		